the kids dentist

Tell us about your child

Patient's Name: First: _____ Middle: _____ Last: _____

Nickname: _____ Date of Birth: _____ ☐ Male ☐ Female

Patient's Address: _____
Street Address City State Zip

Other siblings seen by our office: _____

Previous dentist: _____ Last visit date: _____

Patient's physician: _____

Parent's Information

☐ Mother ☐ Step Mother ☐ Guardian ☐ Other

Primary Contact Name: _____ Date of Birth: _____

Address: _____ Email: _____
Street Address City State Zip

Cellular phone: _____ Secondary phone: _____

Employer: _____ Occupation: _____ SSN: _____

☐ Father ☐ Step Father ☐ Guardian ☐ Other

Name: _____ Date of Birth: _____

Address: _____ Email: _____
Street Address City State Zip

Wireless phone: _____ Secondary phone: _____

Employer: _____ Occupation: _____ SSN: _____

Primary Dental Insurance

Insurance company name: _____ Group: _____ Phone: _____

Insurance company mailing address: _____
Street Address City State Zip

Policy owner's name: _____ DOB: _____ ID: _____

Policy owner's SSN: _____ Relationship to patient: _____

Policy owner's employer: _____

Secondary Dental Insurance

Insurance company name: _____ Group: _____ Phone: _____

Insurance company mailing address: _____
Street Address City State Zip

Policy owner's name: _____ DOB: _____ ID: _____

Policy owner's SSN: _____ Relationship to patient: _____

Policy owner's employer: _____

Other

Concerns for this visit: _____

Does your child have any oral habits? ☐ Thumb/digit habit ☐ Nail biting ☐ Pacifier
☐ Lip sucking ☐ Other: _____

Please provide the best cell phone number for confirmation texts: _____

Please provide the best email address for confirmation emails: _____

I hereby grant permission to the staff of this office for the administration of such anesthetics and the performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information as answered on this form is correct to the best of my knowledge.

I understand that I am financially responsible for the payment of any services rendered as well as broken appointment fees and all late payment service charges. Should I have dental insurance, I also understand that obtaining insurance coverage and benefit information as well as keeping up with the ever changing polices of my unique plan is my responsibility.

Signature: _____ Relationship to child: _____

Parent/guardian name: _____ Date: _____